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Conversion Hysteria—An Explanation for Attorneys

Ewing H. Crawfis*

“CONVERSION HYSTERIA” is a diagnostic term used by physicians and particularly in one specialty of medicine—namely psychiatry. Attorneys encounter this term as it is applied to certain individuals who come to them in the course of their practice particularly in cases involving personal injury and claims for compensation. This paper is being presented in an effort to explain and clarify this diagnostic term for attorneys.

The term hysteria is an inappropriate one. It has a very long history and the word itself is derived from the Greek word for “uterus.” In this illness, the ancient physicians believed that the uterus had the ability to wander about the body and the symptoms were supposed to be due to its action in its new location. Obviously—in the light of modern knowledge—this antiquated explanation and the term itself cannot be regarded as either scientific or appropriate but the term does continue to be in common use. The diagnostic term which is more appropriate and is the subject of present day usage is “conversion reaction.” This diagnostic category is a sub-group of a major diagnostic grouping called psycho-neuroses or simply neuroses. Some of the other reactions which occur as sub-groups under the neuroses are anxiety reactions,—phobic reactions,—obsessive-compulsive reactions, and depressive reactions.

It is well to remember that most of the symptoms of emotional and mental illness are exaggerations of normal reactions. The difference between people of this kind and the normal individual is more often one of quantity rather than quality. Drawing clear-cut lines of distinction is frequently difficult. The normal tends to blend in to the borderline and the borderline into the abnormal. Let us first consider the neuroses as a whole and then proceed to consider conversion.

The neuroses are a major group in the classification of emotional and mental illnesses. They may be considered as sub-

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stitutive reactions in which the patient's symptoms have a role in his mental workings. The symptoms tend to serve a purpose and represent an effort to solve some conflict in the individual's life situation. The neuroses are differentiated from the psychoses in that they are usually less severe. Distortion and disorganization of the personality is not present. Actually, the differentiation in this sphere is more apparent in the social behavior and outward adjustment of the patient in that the neurotic may have considerable internal disturbance and may be as disturbed internally in his emotional state as the psychotic patient. However, in the neurotic, this inner stress and disturbance does not produce the marked alterations in the external behavior and the social adaptability that is seen in the psychotic person. Another differentiating factor in the neurotic is that the mental apparatus which perceives and measures reality is relatively intact. This means that the neurotic remains sensitive to changes in his social environment and is able to make appropriate adjustments to such changes whereas the psychotic individual frequently suffers serious impairment in his ability to perceive and adjust to such changes.

We should also differentiate the neuroses from malingering, which is the conscious simulation of symptoms. This is particularly important in cases in which compensation is involved. Here, it should be pointed out that there are persons who consider all neurotics but most particularly hysterics as malingerers, i.e. they refuse to accept the patient's symptoms as being real, and they believe that he can control his symptoms. For the well trained physician, the differentiation is usually not difficult—symptoms of an illness generally form an orderly pattern. The malingerer usually presents sufficient discrepancies and contradictions in the pattern of his symptoms to enable the physician to make the diagnosis. Observation of the patient of which he is unaware is helpful and may make the differentiation for the physician. It is, of course, a tool which is most useful to the attorney.

I should like to re-emphasize the fact that the classification of the psycho-neuroses into the various types is often difficult. In addition to the merging and blending of these various types, it should be pointed out that they are not well defined entities, either from the standpoint of cause or symptoms. Another confusing factor is that the same term is frequently used for a single symptom as well as a diagnostic label for a whole grouping of

symptoms. For example—*anxiety* is a term which refers to a symptom or a set of symptoms. *Anxiety*—when used to describe a symptom, frequently occurs in other psychiatric disorders as well as the *psycho-neuroses*. Also, *anxiety state* is a term which is applied to a category or a sub-group of the *psycho-neuroses* and as such is a diagnostic label rather than a label for symptoms. The same situation occurs with the term *conversion*. It is used to describe a mental mechanism, and a set of mental symptoms, and is also used as a diagnostic label for the sub-group which is called “*conversion hysteria*.” It should be made clear then, that the *conversion mechanism* can and does operate in other psychiatric disorders but that in *conversion hysteria* the mechanism and the symptoms of *conversion* are predominant.

With the preceding material as background—let us now proceed to some consideration of *conversion*. Before explaining the mental mechanism of *conversion*, it is necessary to describe the one called *repression*. This is the mechanism by which impulses, desires and other thoughts which are painful or unacceptable to the individual's consciousness are moved from the area of awareness into the area of unawareness which we call the unconscious. This is not a conscious nor a voluntary action but it is rather an unconscious process and it operates normally in all of us. It should not be confused with *suppression* in which the same process is conscious and deliberate. *Repression* goes on all of the time and allows us to ignore things which might otherwise greatly disturb us. The disadvantage of this mental mechanism is that the energy of our drives, urges, and desires is not eliminated by the process of *repression*. This energy remains with us, is stored and tends to be built into an increasing potential. As it increases in potential, it seeks release or discharge. If the energy outlet is diverted toward useful and socially acceptable goals, the process is known as *sublimation*. If the energy is not directed outwardly in such a manner, it may be released in the form of symptoms or emotional disturbance.

In *conversion*, the energy which has been repressed is released in the form of an alteration of a physical or a physiological function which creates physical disability. This process of alteration is poorly understood and the selection of the particular physical function is also poorly understood. However we do know that the resulting disability serves some purpose in the life of the individual and has some meaning to him although this meaning is hidden and not understood by him.

At any rate, we see that the problem or the emotional conflict has been converted into a physical symptom. This symptom is in a disguised form and affords the patient relief from his emotional problems, although he may not recognize this. Usually, the form and character of the physical symptom bears some relationship to the repressed material which has been converted. Examples of the physical symptoms of conversion are paralysis—blindness—deafness—inability to talk—anaesthetic areas, etc.

The conversion reaction is accompanied by what we call "secondary gain"; that is—it enables the patient to maintain self respect, and at the same time he is able to achieve something which his own integrity would not have permitted. Thus, it may serve as an attention-getting mechanism, or permit an escape from a difficult situation. It frequently is an excuse for failure. It should again be pointed out that this process is unconscious, and that the secondary gain is hidden from the patient by himself. This point needs to be emphasized since quite frequently the "secondary gain" is obvious to the patient's family and friends, and they assume that it is equally obvious to the patient. It is one of the reasons why these conditions are assumed to be self-controlled by the patient.

The factor of "secondary gain" is important, because it tends to perpetuate and prolong the illness. It is for this reason among others that many of these conditions tend to become chronic, since the patient is unconsciously reluctant to be cured of the disability, because of its advantages or gains. In the traumatic neuroses, the factor of compensation is a very important one, usually because it is involved in the "secondary gain."

I referred previously to the symptom of anxiety. In the well developed and classical conversion reaction, one of the important diagnostic clues is the lack of anxiety. The lack of concern and calm acceptance of his physical disability is usually significant.

In cases in which the physical disturbances predominate, the diagnosis may become apparent from the discrepancy between the symptoms and the findings on examination. Referring to some of the examples previously cited; in paralysis—the reflex changes are usually at variance with the paralysis, and the muscles do not show the atrophic changes. Likewise, the paralysis may be selective, one voluntary action being present while another is not; in blindness, the reflexes are intact also and frequently the patient unconsciously avoids collision with objects;

in deafness—hearing loss is usually not typical as compared to ordinary tests in deafness in which changes are more marked in some tonal ranges than others; in conversion reactions, the symptom of mutism is accompanied by other functions, such as writing, which might well be lost in the true organic neurological lesion; in anaesthesia, the distribution of the area does not follow that of the normal nerve pattern but is that which the patient believes it to be—the so called “glove” anaesthesia being an example. It is not the purpose of this paper to describe the differential diagnosis of conversion. This is the function of the examining physician. I have presented the above brief material for one purpose only. This is to indicate that there are methods of evaluation by which the diagnosis can be made positively in almost every case. Unfortunately, too frequently, the diagnosis is made on a negative basis by the process of exclusion—i.e. by the elimination of organic factors. While exclusion is a part of the process of diagnosis, one should not make a diagnosis on this basis alone, but must give consideration to the emotional life problems of the patient, in order to arrive at the diagnosis of conversion on the basis of positive factors involved.

There are two other terms used by the medical profession which merit our consideration at this time.

The first of these is compensation neurosis. This term is applied to those illnesses which may be either industrial or the result of accidental injury in which the factor of “secondary gain” is the most prominent feature. The majority of them are conversion reactions although it should be made clear that other neurotic reactions can occur.

Frequently, the patient is preoccupied with his efforts directed at securing damages or compensation or benefits of some kind. This concern may be obsessive and it may be so overwhelming that the illness may be classified as an obsessive reaction, or obsession may be only one of several other symptoms. The physician in the case is likely to find himself involved and to tend to take sides. It is difficult to remain unbiased in one's efforts to evaluate the individual case. In addition the outcome of the illness may be determined upon the outcome of litigation rather than the particular line of treatment adopted by the physician.

The term compensation neurosis actually is a poor one from several points of view. Diagnostically, it lays emphasis upon one factor—namely, that of secondary gain rather than being

descriptive of the symptom picture presented by the patient. More importantly, the name prevents a logical or sympathetic understanding of the illness which is unconsciously determined. It is an emotionally "loaded" term. In this connection, it might be interesting to call attention to a recent paper by Dr. Gotten of Memphis. He studied one hundred cases of neck injury following auto accidents after the legal claims for damage were completed. He found that psycho-neurotic symptoms, once they had developed, persisted for many months. They were resolved to a great extent by the settlement of litigation. One of the most interesting comments made in his paper was that the results—whether the patient was improved or not improved,—seemed to have little relationship to whether the patient felt satisfied with the outcome of the settlement. His final conclusion was that many emotional factors, but especially those concerning monetary compensation, greatly confuse proper medical evaluation and appear to be the cause of the wide divergence of professional prognostic opinion relative to this particular type of injury.

The second term is traumatic neurosis or more properly post-traumatic neurosis. This term is applied to neurotic reactions which have been attributed to or which follow some traumatic event or a series of such events. Any type of neurosis can follow trauma. The effect of trauma can have wide variations—it may serve to precipitate an incipient or latent neurosis. It may aggravate an already existing neurosis or it may seem to have directly caused the illness. The common factor in all cases is that the onset of the illness follows the trauma. If the trauma is industrial, or accidental, with compensation involved, then it becomes obvious that the terms traumatic neurosis and compensation neurosis become synonymous—or possibly it would be better to say that they become concurrent.

The term has also been applied to combat and war neuroses. More recently, the changes which have been induced by "brain washing," have been included in the traumatic neuroses. In this category, while physical trauma may be a factor, the major factor is psychological trauma which is carefully but insidiously and cruelly applied in a repetitive fashion over a prolonged period of time. The fact that even emotionally strong persons do have a breaking point, if certain facets of their personality structure are exploited, is clearly brought out by this process.

This discussion leads us to a consideration of a basic concept of emotional illness. In one sense, all of our emotional disorders

might be regarded as traumatic. Trauma, usually of a psychological character, may be thought to lay the early foundations upon which later emotional illnesses may develop. However, we now tend to broaden the term trauma to the term *stress*. All of us undergo stress of varying kind and degree. The difference lies in the highly variable capacity to tolerate it on an individual basis. The pre-existing personality experience and adjustment are most important in the determination of the response of any one individual to the stress he encounters. Thus the reaction or response of a person to stress is the sum total of his personality adjustment plus the kind and degree of the stress of the situation at hand. The individual response to any stress must be measured in terms of the meaning of that stress to the person involved.

On this basis, one can understand that the degree of emotional disturbance which follows from a traumatic experience is not in direct proportion to the intensity of that experience. In one instance a severe neurosis may follow minor stress, and in the next instance, only a moderate neurosis may follow maximal stress.

The neurosis affects the whole personality structure, and tends, in symptoms, to exaggerate certain characteristics of the personality. While it has already been stated that the pre-existing personality will determine the kind of response, this should not be taken to imply weakness of the personality. Unfortunately, when the physician describes a patient as having a psychoneurotic personality, or having a predisposition toward the development of a neurosis, this is taken to mean an inherent weakness for which the patient should be condemned.

All of us have a predisposition toward one type of illness, or another, and the question of whether we will develop such an illness seems to be dependent on chance—that is, whether we encounter stress of the particular type to which we are susceptible and in sufficient degree in our individual case to produce illness.